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Medicare+Choice Payments

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Summary

In 1997, Congress passed the Balanced Budget Act of 1997 (BBA, P.L. 105-33), which included provisions to create the Medicare+Choice (M+C) program. This legislation redesigned the system for setting Medicare payment rates for health maintenance organizations and other private plans that contract with Medicare. The new payment structure is designed to reduce variation in payments across the country by increasing payments in areas where they are traditionally low and slowing the rate of growth in areas with higher payments.

The M+C program also established new rules for beneficiary and plan participation. These new rules were devised to expand health plans to markets where access to managed care plans was limited or non-existent, and to offer new types of health plans in all areas. The M+C program has had limited success at expanding coverage, and the initial moderate growth which increased M+C enrollment has been on a downward turn since 2001.

In 1999, Congress enacted the Balanced Budget Refinement Act of 1999 (BBRA, P.L. 106-113) to address some of the issues arising from the passage of the BBA. The BBRA included changes to the M+C program in an effort to make it easier for Medicare beneficiaries and plans to participate in the program. Further refinements to the M+C program were included in the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, (BIPA, P.L. 106-554).

This report focuses on M+C payments. For a discussion on the recent trends in Medicare managed care, along with an overview of the M+C program, see CRS Report RL30702, *Medicare+Choice*.

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Introduction

Medicare has a long-standing history of offering its beneficiaries an alternative to the traditional fee-for-service program, in which a payment is made for each individual Medicare-covered service provided to a beneficiary. Beginning in the 1970's, private health plans were allowed to contract with Medicare on a cost-reimbursement basis. In 1982, Medicare's risk contract program was created, allowing private entities, mostly health maintenance organizations (HMOs), to contract with Medicare. In exchange for a preset monthly per capita payment from Medicare, private health plans agree to furnish all Medicare-covered items and services to each enrollee.

Then, in 1997, Congress passed the Balanced Budget Act of 1997 (BBA, P.L. 105-33), replacing the risk contract program with a new Medicare+Choice (M+C) program. The M+C program established a new payment structure, designed to reduce the variation across the country by increasing payments in areas with traditionally low payments, and slowing the rate of growth in areas with higher payments. However, although payment variation has been somewhat reduced, substantial payment differentials remain nationwide.

The M+C payment structure was implemented beginning in 1998.[1] In general, the program makes monthly payments in advance to participating health plans for each enrolled beneficiary in a payment area (typically a county). The Secretary of Health and Human Services (HHS) is required to determine annually, and announce by March 1 in the year before the calendar year affected, the annual M+C per capita rate for each payment area, and the risk and other factors to be used in adjusting such rates. Payments to M+C organizations are made from the Medicare Trust Funds in proportion to the relative weights that benefits under Parts A and B represent of the actuarial value of total Medicare benefits.

The M+C program also established new rules for beneficiary and plan participation, along with the new payment methodology. The program was designed to expand the availability of health plans in markets where access to managed care plans was limited or non-existent, and to offer new types of health plans in all areas. In order to increase enrollment in Medicare managed care, and to allow beneficiaries access to similar options available in the non-Medicare market for meeting health care needs, the M+C program offers a diverse assortment of managed care plans. However, achieving these goals has been difficult, in part because the goal to control

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[1] Although the M+C payment structure was implemented in 1998, most of the other components of the M+C program were effective in 1999.

Medicare spending may have dampened interest by managed care entities in developing new markets, adding plan options, and maintaining their current markets.

The 106th Congress enacted legislation in order to address some of the issues arising from the BBA changes. The Balanced Budget Refinement Act of 1999 (BBRA, P.L. 106-113) as well as the Medicare, Medicaid, and SCHIP Benefits Improvements and Protection Act of 2000 (BIPA, P.L. 106-554) amended the M+C program in an effort to increase reimbursement and to make it easier for Medicare beneficiaries and plans to participate in the program.

Calculation of the Medicare+Choice Payment Rate

The major factors for determining Medicare's annual M+C per capita rates are summarized in **Table 1**. The annual M+C per capita rate for a payment area (for a contract in a calendar year) is set at the highest of one of three amounts calculated *for each county*:

- a rate calculated as a blend of an area-specific (local) rate and a national rate,
- a minimum payment (or floor) rate, or
- a rate reflecting a minimum increase from the previous year's rate.

Each part of the system is described in more detail below.[2]

Blended Rates

The blended per capita rate shifts county rates gradually away from solely local (generally county) rates, which reflect the wide variations in fee-for-service costs, toward a national average rate. Blending is designed to reduce payments in counties where the adjusted average per capita costs[3] (AAPCCs) historically were higher than the national average rate, and to increase payments in counties where AAPCCs were lower. The blended rate is defined as the weighted sum of:

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[2] A state may request a geographic adjustment to a payment area to establish a single statewide M+C area, a metropolitan based system, or the consolidation into a single area of noncontiguous counties. For disabled and ESRD beneficiaries, payment rates are set using a similar method as that for aged beneficiaries, except that ESRD rates are calculated on a statewide basis. Beginning in January 2002, BIPA requires the Secretary to increase M+C payment rates for enrollees with ESRD. The revised rates will reflect the demonstration rate (including the risk-adjustment methodology) of social health maintenance organizations' ESRD capitation demonstrations and include adjustments for factors such as renal treatment modality, age, and underlying cause of the disease.

[3] Prior to enactment of the BBA, payments for care of Medicare beneficiaries in risk health maintenance organizations (HMOs) were based on the AAPCC. The AAPCC represented a monthly payment to cover the cost of treatment in a Medicare risk HMO. It was calculated according to a complex formula based on the cost of providing Medicare benefits to beneficiaries in the fee-for-service portion of the Medicare program. The per capita payment was set at 95% of the AAPCC, and was adjusted for certain demographic characteristics of HMO enrollees.

- a percentage of the annual area-specific M+C per capita rate for the year for the payment area, and

- a percentage of the input-price adjusted annual national M+C per capita rate for the year.

The component of the blend determined by the area-specific (local) rate is based on the 1997 AAPCC for the payment area with two adjustments. First, the area-specific rate is reduced to remove an amount corresponding to graduate medical education (GME)[4] payments. Second, rates are updated each year by a national growth percentage (described below). The component of the blend determined by the national rate is a weighted average of all local area-specific rates. This component of the blend is adjusted to reflect differences in certain input prices, such as hospital labor costs, by a formula stated in the law. The BBA allows the Secretary to change the method for making input-price adjustments in the future.

Under current law, the percentage in the blend assigned to the area-specific rate is reduced in increments over 6 years from 90% in 1998 to 50% in 2003, while the corresponding percentage for the national component is increased from 10% to 50%. In 2003, the blended rate will be based on 50% of the area-specific rate and 50% of the national, input-price adjusted rate. Each year, the blended rates may be raised or lowered to achieve budget neutrality (explained below).

Minimum Payment (Floor) Rate

Each county is also subject to a floor rate, designed to raise payments in certain counties more quickly than would occur through the blend alone. Initially, the BBA provided for a floor rate that would apply to all counties *within* the United States and for 2000 this minimum rate was $402 per month. A separate minimum was also established for areas *outside* (i.e. territories) the United States. Beginning March 2001[5], BIPA established multiple floor rates, based on population and location. For 2001, the floor was $525 for aged enrollees *within* the 50 states and the District of Columbia residing in a Metropolitan Statistical Area (MSA) with a population of more than 250,000. For all other areas *within* the 50 states and the District of Columbia, the floor was $475. For any area *outside* the 50 states and the District of Columbia, the $525 and $475 floor amounts were also applied, except that the 2001 floor could not exceed 120% of the 2000 floor amount. As required by law, these payment amounts are increased annually by a measure of growth in program spending (see discussion of national growth percentage, below). In 2002, the floor is $553 for the larger MSAs and $500 for the smaller MSAs. For 2003, the

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[4] Medicare pays for the both the direct and indirect costs of GME. Direct payments include payment for expenses such as salaries of residents, interns and faculty. The indirect adjustment accounts for factors not directly related to education which may increase the costs in teaching hospital, such as more severely ill patients and increased testing.

[5] Generally, increases in M+C payments are effective on January 1, of each year. However, the changes resulting from BIPA were effective on March 1, 2001. As a result, M+C plans were paid at a pre-BIPA rate for January and February of 2001, and then beginning in March the new rates went into effect. In future years, increases will be effective on January 1.

preliminary floor amounts will lower the floor to $548 for the larger MSAs and $495 for the smaller MSAs[6]. In 2003, M+C payments in only six counties will be based on the floor payments, because these counties were able to change their designation from a low floor county payment area to a high floor county payment area[7]. The 2003 payments to M+C organizations in these counties will be based on the floor payment of $548.

Minimum Percentage Increase

The minimum increase rule protects counties that would otherwise receive only a small (if any) increase. In 1998, the minimum rate for any payment area was 102% of its 1997 AAPCC. For 1999 and 2000, the increase was 102% of the annual M+C per capita rate for the previous year. BIPA applied a 3% minimum update for 2001, beginning in March. For subsequent years, the minimum increase returned to an annual January update of an additional 2% over the previous year's amount. The minimum percentage increase is the only positive update for 2003 M+C payments.

Exclusion of Payments for Graduate Medical Education (GME)

Payments for GME are excluded or "carved out'" of the payments to M+C plans over 5 years. Specifically, in determining the local rate prior to determining the blended rate, amounts attributable to payments for GME costs were deducted from the 1997 payment amount. The percent of GME payments excluded began at 20% in 1998, rising in equal amounts until it is fully deducted in 2002. However, the GME "carve out" will not occur in a year in which no payment is based on the blended rate, because this carve out only applies to the blended rate and not to either the minimum percentage increase of the floor rate. Payments for disproportionate share hospitals (DSH)[8] are not carved out.

Budget Neutrality

Once the preliminary rate is determined for each county, a budget neutrality adjustment is required by law to determine final payment rates. This adjustment is made so that estimated total M+C payments in a given year will be equal to the total payments that would be made if payments were based solely on area-specific rates. A budget neutrality adjustment may only be applied to the blended rates because rates cannot be reduced below the floor or minimum increase amounts. As a result of this limitation, it is not always possible to achieve budget neutrality. The law makes no

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[6] See discussion of national growth percentage for an explanation of how the adjustment for prior year's errors actually lowers the floor payments in 2003.

[7] M+C payments for five of these counties is set at the lower floor rate in 2002, while payments for the sixth county is set at the minimum update rate in 2002. Regardless of their actual 2002 payment amount, the high floor amount yields the highest M+C payment for each of these six counties in 2003.

[8] DSH payments are a payment adjustment for the higher costs that hospitals incur as a result of serving a large number of low income patients.

Table 1. Major Factors for Determining Medicare
Payments to Medicare+Choice Plans

Factor	Rule established in BBA 97, BBRA 99, or BIPA	
Blend of local and national rates	General	Transition over 6 years to 50-50 blend of local and national rates. National rates are adjusted for differences in input prices.
	1998	90% local, 10% national
	1999	82% local, 18% national
	2000	74% local, 26% national
	2001	66% local, 34% national
	2002	58% local, 42% national
	2003 and after	50% local, 50% national
Minimum payment (floor) rate	1998	Minimum of $367 (or 150% of 1997 payment outside United States)
	1999 and after	Previous year's payment times annual percentage increase, except for 2001 when the amount was set in law ($380 for 1999, $402 for 2000, and $525/$475 for 2001-or 120% of 2000 payment outside US, and $553/$500 for 2002)[9]
Minimum percent increase	1998	102% of 1997 AAPCC payment rate
	1999 to 2000	102% of prior year's rate
	2001	103% of prior year's rate
	2002 and after	102% of prior year's rate
GME and DSH	General	GME payments excluded (from blended rate only) in equal increments over 5 years. DSH payments not excluded.
Budget neutrality	General	Total M+C payments must equal what would have been spent if payments were entirely based on local rates (except no rate can be reduced below the floor or minimum)
National growth percentage	1998	Increase in Medicare per capita expenditures (MPCE) minus 0.8 percentage points
	1999-2001	Increase in MPCE minus 0.5 percentage points
	2002	Increase in MPCE minus 0.3 percentage points
	2003 and after	Increase in MPCE
Risk adjustment	2000-2003	10% health status, 90% demographic
	2004	30% inpatient and ambulatory, 70% demographic
	2005	50% inpatient and ambulatory, 50% demographic
	2006	75% inpatient and ambulatory, 25% demographic
	2007 and after	100 % inpatient and ambulatory

Source: Congressional Research Service analysis of provisions in BBA, BBRA, and BIPA.

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[9] Beginning in 2001, there is a higher floor payment for counties in the US with a population of more than 250,000 and a lower floor payment for all other counties in the US .

provision for achieving budget neutrality after all county rates are assigned either the floor or minimum increase. When this situation occurred for the 1998, 1999, 2001, and 2002 rates, the Centers for Medicare and Medicaid Services (CMS) chose to waive the budget-neutrality rule rather than the floor or minimum rate rules. While the cost of waiving budget neutrality was not significant in 1998 and 1999 (less than $100,000 each year), the cost in 2001 was about $1 billion.

National Growth Percentage

The national per capita M+C growth percentage is defined as the projected per capita increase in total Medicare expenditures minus a specific reduction set in law. Because this increase is tied to total Medicare expenditures, it maintains a link between Medicare fee-for-service and managed care spending. In 1998, the reduction was 0.8 percentage points, from 1999 through 2001 it is 0.5 percentage points, and in 2002 the BBRA set the reduction at 0.3 percentage points. There is no reduction after 2002. Starting with the 1999 M+C payments, adjustments were also made for errors in the previous years' spending projection.

The national growth percentage for 2001, after the reduction and adjustments, was -1.3%. This figure[10] is based on a 6.0% projected per capita increase in total Medicare expenditures, a 0.5 percentage point reduction set by the BBA, and a minus 6.5% adjustment for errors in the previous years' projection of spending (1998 through 2000). However, the adjustment for 1998 errors in previous years' projections of spending is excluded from the calculation when updating the floor rates. This would have resulted in an overall increase of 3.3% to be used for calculating the floor rate, for 2001, as opposed to the -1.3% national growth percentage. However because BIPA set the floor rates in 2001, the national growth percentage was not used to calculate the floor rate in 2001. It was only used to calculate the blend rate for 2001.

For 2002, the estimated national growth percentage increase over the pre-BIPA payment amount (used for January and February of 2001) is 8.3%[11]. This figure is based on a 5.6% projected per capita increase in total Medicare expenditures, a 0.3 percentage point reduction set by the BBRA, a minus 0.3% adjustment for errors in the previous years' projection of spending (1998 – 2001), and an increase of 3.2% to account for the impact of BIPA. The increase used to calculate the floor payment for 2002 is 5.3%, reflecting only the projected per capita increase in total Medicare expenditures of 5.6% and the 0.3 percentage point reduction set by the BBA. There is no adjustment for prior year errors, as the floor amounts were reset by the amounts established in BIPA.

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[10] Numbers are not exact, due to rounding.

[11] Because BIPA increased M+C payments beginning in March 2001, CMS calculated a revised national growth percentage of 4.9% for 2002 to be applied to these new BIPA payment levels. The difference between the revised national growth percentage increase and the original increase is the 3.2% increase for BIPA adjustments. It is not necessary to include this 3.2% adjustment in the revised increase, as it is already reflected in the March 1, 2001 payment levels.

For 2003, the projected national growth percentage increase is actually a decrease of 2.9%. This decrease reflects a 0.9% increase in per capita costs and a negative 3.8% adjustment for prior years' errors. The -2.9% factor is used to update the 2002 blend rate. The 2003 update for the floor is -1%, reflecting the same 0.9% increase in per capita costs, but only a 1.9% decrease for the prior year error in 2002 estimates[12]. Because both of these updates are negative, the minimum percentage increase (the only positive update) yields the highest M+C payment for all counties except those few that were able to change their designation to receive payment at the higher floor rate.

Bonus Payments

BBRA established a bonus payment to encourage new M+C plans to enter counties that would otherwise not have a participating plan. The first plan to enter a previously unserved county (or an area where all organizations announced their withdrawal from the area as of October 13, 1999) would receive a 5% added payment during their first year and a 3% added payment during their second year. BIPA further extended these bonus payments for M+C plans to include areas for which notification had been provided, as of October 3, 2000, that no plans would be available January 1, 2001. For 2001, 10 M+C contracts qualified for these bonus payments for some of the counties located the following states; Mississippi, Iowa, South Dakota, Oregon, Wisconsin, Minnesota, Florida, New York, as well as for some counties in states served by the Sterling Private Fee-for-Service Plan[13].

Risk Adjustment

M+C payments are also risk adjusted to control for variations in the cost of providing health care among Medicare beneficiaries. For example, if sicker and older patients all sign up for one M+C plan, risk adjustment is designed to compensate the plan for their above average health expenses. The former Medicare risk contract program adjusted the AAPCCs for demographic risk factors, and when the M+C program was implemented, it also used these demographic risk adjusters. Demographic risk adjusters include those for age, gender, working status, Medicaid coverage, whether the beneficiary originally qualified for Medicare on the basis of disability, and institutional (nursing home) status.

However, these demographic risk adjusters account for only a very limited portion of the variation in health care costs, and as a result, the BBA required the Secretary of HHS to develop a new risk adjustment mechanism that would also account for variations in health status. Beginning in January 2000, CMS implemented this new risk adjustment mechanism built on 15 principal inpatient

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[12] Because BIPA reset the floor payments in 2001, adjustments will only be made for prior year errors occurring in 2002 and beyond.

[13] Sterling qualified for a bonus in some of the counties located in Alaska, Arkansas, Idaho, Kentucky, Louisiana, Minnesota, Mississippi, Nebraska, Nevada, New Mexico, and Ohio. (For a more detailed discussion of Medicare Private-Fee-for-Service plans, see CRS report RL31122, *Medicare+Choice: Private Fee-for-Service Plans*, by Paulette Morgan and Madeleine Smith.)

diagnostic cost groups (PIP-DCGs). Payments are adjusted based on inpatient data using the PIP-DCG adjuster and demographic factors, so that this new system accounts for both demographic and health-status variations. Under this mechanism, the per capita payment made to a plan for an enrollee is adjusted if that enrollee had an inpatient stay during the previous year. Separate demographically-based payments are used for newly eligible aged persons, newly eligible disabled Medicare enrollees, and others without a medical history.

The BBRA and BIPA made changes to the Secretary's proposed phase-in schedule of this new system, through 2002. Plans were concerned because this new risk adjustment methodology reduces aggregate M+C payments; slowing down its implementation lessens the reduction. Through 2003, 10% of payments will include risk adjustment using the PIP-DCG method and 90% will be based solely on the older demographic method.

BIPA made additional changes to risk adjustment so that beginning in 2004, a new risk adjustment methodology will be phased-in based on data from not only inpatient hospitals but also from ambulatory settings as well, in order to account for more of the variation in health status. This new risk adjustment will be phased in at the rate of 30% in 2004, 50% in 2005, and 75% in 2006 and 100% beginning in 2007. In March 2002, CMS announced that the new risk adjustment methodology would be based on a "selected significant condition" model comprised of approximately 61 disease groups chosen because of their statistical and clinical significance for the Medicare population. Beginning July 1, 2002, M+C organizations must collect information on the selected diagnoses (and must submit that data to CMS beginning October 2002).

One further change required by BIPA, although temporary, fully implemented risk adjustment based on inpatient hospital diagnoses for an individual who had a qualifying congestive heart failure inpatient diagnosis between July 1, 1999 and June 30, 2000, if that individual was enrolled in a coordinated care plan offered on January 1, 2001. This applied for only 1 year, beginning on January 1, 2001. This payment amount was excluded from the determination of the budget neutrality factor.

# Variations in Medicare+Choice Payment Rates

A M+C payment area is defined as a county or equivalent area specified by the Secretary. (In the case of individuals with end stage renal disease (ESRD), the M+C payment area is each state, or other payment areas as the Secretary specifies.) Upon request of a state for a contract year, the Secretary will redefine M+C payment areas in all or a portion of the state to: 1) a single statewide payment area; 2) a metropolitan system; or 3) a single payment area consolidating noncontiguous counties (or equivalent areas) within a state.

County Payment Rates

As noted above, each county rate is set at the highest amount calculated under three rules (blend, minimum increase, and floor), and then adjusted for budget

neutrality. Because of the low national growth percentage in 1998 and 1999, no county rate was set by the blended-rate rule after applying the budget neutrality adjustments (**Figure 1**). In 2000, the national growth percentage was sufficiently large (5%), so that payments in 60% of counties were based on the blended-rate rule. However, the national growth percentage for 2001 was-1.3%, as previously discussed. Therefore, in 2001, no county was paid using the blended-rate rule and about 72% all county payments were set at the floor, with the remainder of counties receiving the minimum 3% increase. Similarly in 2002, no county is being paid using the blended-rate rule, and about 79% of all counties have their payment set at the floor with the remainder of payments set at the minimum update of 2%. For 2003, all but six counties will have their payments set at the minimum update of 2%.

Figure 1. Rule Used to Determine Country Payment Rates, by Year, 1998-2003

Source: CRS analysis of CMS data
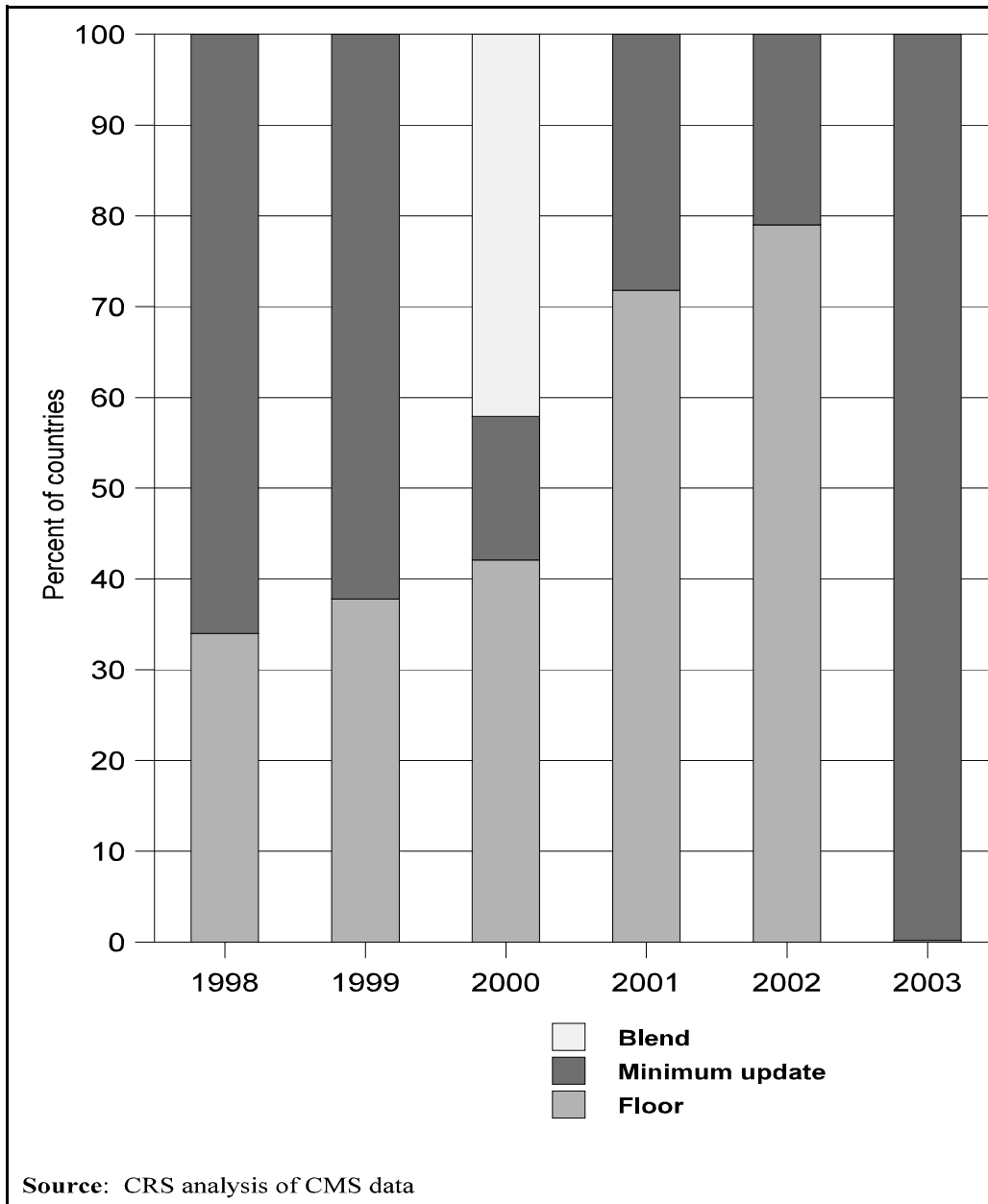
Calculations for selected 2002 county payment rates are shown in **Table 2**. The table shows the calculation under the three rules, as well as the rates before and after any budget neutrality adjustments. For the six counties selected, before application of budget neutrality, there is one whose rates were set using the minimum increase amount (Dade, Florida), three set at the floor (Hennepin, Minnesota; Fairfax, Virginia; and Arthur, Nebraska), and two set at the blended rate (Los Angeles, California and Haines, Alaska). Among the six selected counties, the budget-neutrality adjustment was applied to Los Angeles (payment was reduced to the minimum update) and Haines, Alaska (payment was reduced to the floor). For the 2002 payment rates, the adjustment to the blended rate across all affected counties is insufficient to completely achieve budget neutrality.

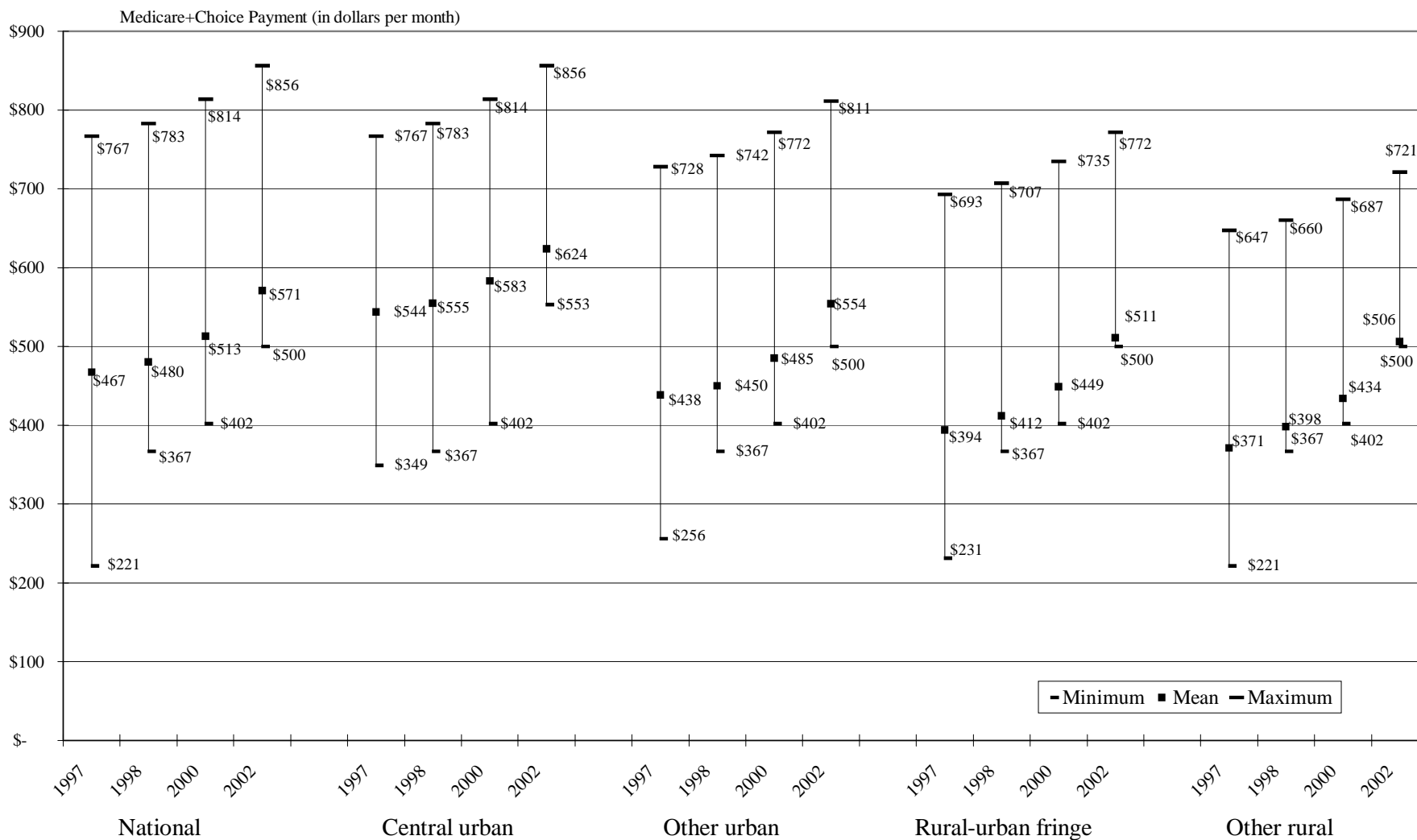**Table 2. Calculation of Monthly Payment Rates for Selected Counties**

	2002				
	Calculation using each of the three separate rules			Determination of rates	
County	Minimum update	Floor	Blend 58% local and 42% national)	Before budget neutrality adjustment	Actual rate (after budget neutrality adjustment)
Los Angeles, CA	$ 694	$ 553	$ 695	$ 695	$ 694
Dade, FL	834	553	760	834	834
Hennepin, MN	536	553	521	553	553
Fairfax, VA	536	553	542	553	553
Arthur, NE	485	500	376	500	500
Haines, Alaska	485	500	512	512	500

Source: Congressional Research Service analysis of CMS data.

Geographic Payment Rates

Large variation in county payment rates was one of the motivating forces behind changes enacted in the Balanced Budget Act. The M+C payment method is designed to reduce this variation. Raising the floor and constraining the minimum update for 2001 supported the goal to reduce both the overall variation and to increase the average payment. Even more of this variation across counties could be reduced if two other events occurred: 1) the national growth rate must be sufficiently large, so that a greater number of M+C payments to plans are based on the blend rate rather than the floor or minimum rate; and 2) the blended rate must be weighted more by the national, rather than the area-specific rate. Additionally, as more M+C payments are based on the blend, the budget neutrality adjustment will diminish.

Figure 2. Range of County Medicare Managed Care Payments for the Aged by Location, 1997-2002

Medicare+Choice Payment (in dollars per month)

National — Central urban — Other urban — Rural-urban fringe — Other rural

Legend: — Minimum ▪ Mean — Maximum

Source: Figure prepared by CRS based on analysis of CMS data.
Note: Means weighted by the number of aged beneficiaries per county.

Examining variations across all counties, **Figure 2** shows that the substantial range above and below the average payment rate continues to exist in 2002, although the differences between highest and lowest payment has diminished since the start of the M+C program. For example, in 1997, the average monthly payment rate weighted by the number of Medicare beneficiaries in each county was $467. The lowest rates in the country were $221 in two rural Nebraska counties (Arthur and Banner). The highest rates in 1997 were $767 and $748, respectively, in Richmond County, New York (Staten Island), and Dade County, Florida (Miami). Examining the variation, from highest to lowest payments, the range was $546 in 1997. In 2002, the range has diminished to $356, as the floor rate is $500 (for areas with fewer than 250,000 in population) and the highest rate (Richmond County) is $856. The average payment in 2002 is $571.

Payment rates vary geographically, as well, with higher payments generally occurring in more urban areas (**Figure 2**). The 2001 floor rate mostly affected rural counties, but it raised rates for some urban counties as well. Because no county received the blended rate in 2001, the large variations in payment rates that existed prior to the M+C program, have only been partially reduced. Therefore, payments continue to be higher in urban areas and lower in the most rural areas. The 2002 average payment is $624 in central urban counties, $70 above that for other urban counties, $113 above that for rural-urban fringe counties, and $118 above that for other rural counties.[14] The range within each of the urban – rural categories remains substantial as well.

Payment rates range widely regionally, as well as geographically, as shown in **Table 3**. For example, plans serving Miami are paid an average of $834 per month in 2002, compared with $553 in Fairfax County, Virginia. But even within a region, there can be wide variation in payment rates. The 2002 payment rate for Dade county in Southern Florida is $200 more than the rate for Palm Beach county. Furthermore, plans competing in the same market may receive substantially different payments for beneficiaries who live on opposite sides of a county boundary. As illustrated in the Washington, D.C. metro area, these differing payment levels may affect plan participation and enrollment. However, variation in M+C payments can only be marginally reduced if no county receives the blended rate.

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[14] Central urban counties are the central counties in metropolitan areas of 1 million population or more. Other urban refers to other counties in those metropolitan areas and any county in smaller metropolitan areas. Rural-urban fringe counties are defined as those non-metropolitan counties that are adjacent to a metropolitan area, and other rural refers to non-metropolitan counties not adjacent to a metropolitan area.

Table 3. Monthly Payment Rates for Aged Enrollees in Selected Areas, 2002

| County	Payment rate
Washington, DC-Maryland-Virginia	
Prince George's County, MD	$672
Washington, DC	651
Montgomery County, MD	563
Alexandria City, VA	553
Arlington County, VA	553
Falls Church City, VA	553
Fairfax City, VA	553
Loudoun, VA	553
Fairfax County, VA	553
Southern Florida	
Dade (Miami)	$834
Broward (Ft. Lauderdale)	725
Palm Beach	631
Southern California	
Los Angeles	$694
Orange	640
San Bernardino	594
Riverside	582

Source: Centers for Medicare and Medicaid Services.
Note: These are actual rates paid to M+C organizations, adjusted for risk.

Average Payment Rates

Figure 3 compares average payment rates for two groups: 1) the hypothetical rate if all Medicare beneficiaries were enrolled in M+C plans; and 2) the rate for beneficiaries currently enrolled in M+C plans. The average payment rate across all beneficiaries is lower than the average for actual M+C enrollees because M+C enrollment tends to concentrate in areas with higher payment rates. For example, in 2002 the monthly average across all beneficiaries is about $569, while the monthly enrollee average is about $604. If enrollment were higher across all areas of the country, especially in lower-payment rural areas, the actual average M+C payment would be lower and thus closer to the beneficiary average.

Figure 3. Comparison of Average Monthly Aged Medicare+Choice Payment Rates for All Beneficiaries and Currently Enrolled Medicare+Choice Beneficiaries: 2000, 2001 and 2002

Source: CRS analysis of CMS data
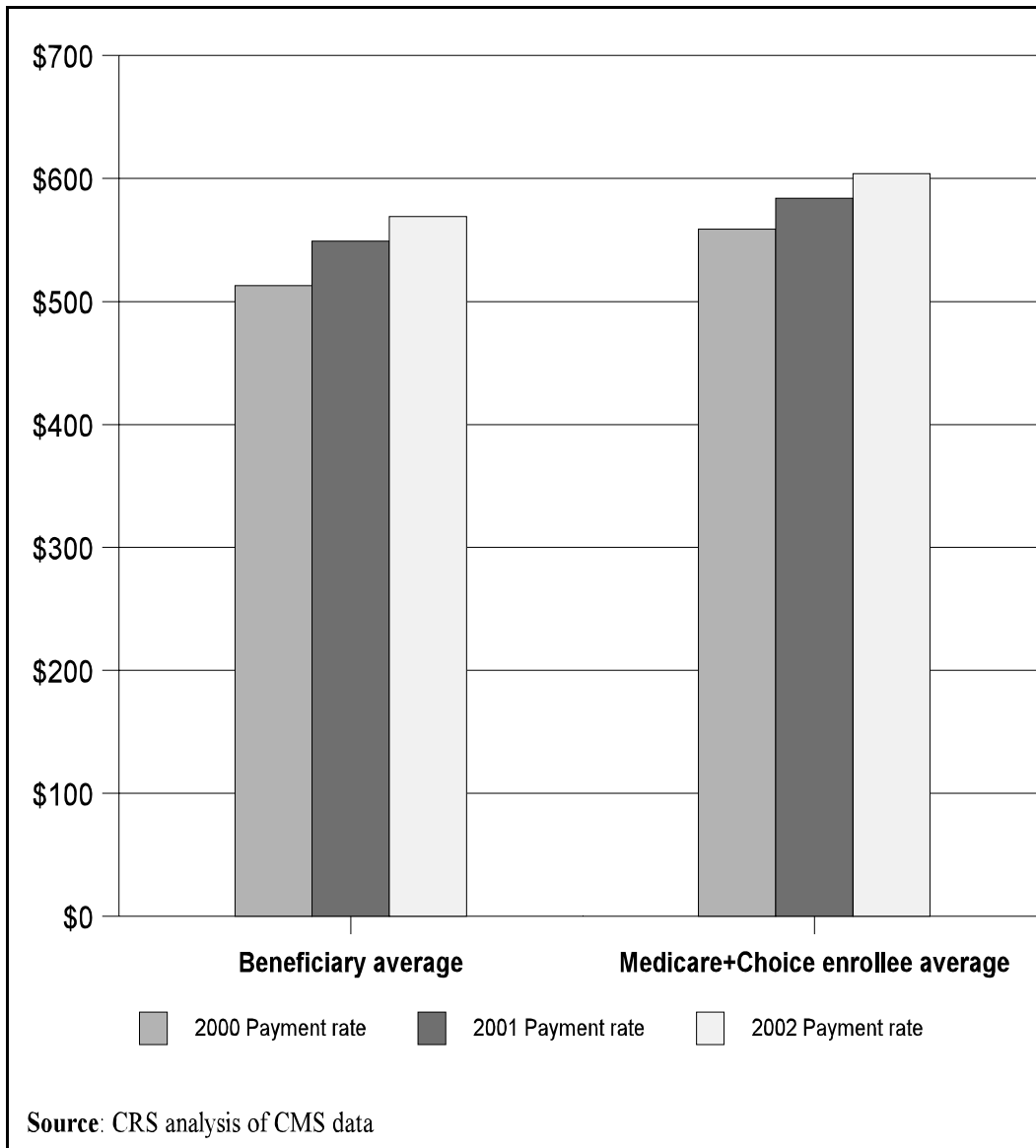
Current Issues of the Medicare+Choice Program

Achieving the goal of expanding Medicare managed care has been difficult, in part because of a competing goal to control Medicare spending. As discussed above, payment increases to plans have generally been limited to the floor and minimum updates, and as a result, managed care entities are less interested in developing new markets, adding plan options, and maintaining their current markets. Next year's planned payment increase of 2% (for all but a few counties) may have a large effect on plan participation decisions, even in those areas where BIPA initially significantly increased floor payments. These limited M+C payment rate increases become even more significant when contrasted with recent higher growth rates for Medicare fee-for-service expenditures. In addition, some plans have scaled back their extra services, such as prescription drug coverage and also increased premiums.

As plans withdraw from the Medicare+Choice program, enrolled beneficiaries are forced to choose new M+C plans, or may be left without any access to Medicare managed care. Even among those who still have an option to choose a health plan, some beneficiaries have selected Medicare's fee-for-service program because they are concerned that additional plan withdrawals could be disruptive to their health care coverage. As plans withdraw from areas, they not only affect current plan enrollees, but they also affect both current Medicare fee-for-service beneficiaries and newly eligible Medicare beneficiaries who are entitled to enroll in an available managed care plan, if they choose to do so.

The M+C program continues to evolve, and as a result, faces new challenges. Modifying the payments to M+C organizations and further reducing variations in payments across the country are possible mechanisms for meeting some of these challenges.